SIHO INSURANCE SERVICES

2021 Benefit Guide

City of Columbus

columbusindiana
unexpected.unforgettable.

www.siho.org

417 Washington Street | P.O. Box 1787 | Columbus, IN 47202-1787 | 812.378.7000

Introduction

The City of Columbus has worked with SIHO, your employee benefits administration company, to develop a benefits plan for you and your eligible dependents.

The SIHO Customer Service staff includes:

Member Services—Representatives who will help you understand your health care benefits and walk you through the claims process.

Medical Management—Nurses are available on site to answer any medical questions you might have or to work with your physician to ensure you receive the highest quality health care.

Account Management—These individuals work with your employer to help them understand how the benefit program is working and to troubleshoot any concerns.

Though City of Columbus cannot avoid the impact of rising health care costs, we believe this health care plan will provide many advantages while living within the city's budget demands.

Advantages of the City of Columbus Plan:

- Two health plans - offering a choice in health care coverage
- Preventive health care coverage, with required educational meetings
- Extensive network of in-network providers

Working Spouse Rule:

The purpose of the Working Spouse Rule is to share the costs of the medical, dental and vision expenses with other plans or insurance carriers when the spouse of an Employee is eligible for medical, dental and vision coverage where the spouse is employed. It is the Employer's responsibility to determine who is eligible for this coverage on a non-discriminatory basis.

1. If a spouse of an eligible Employee is employed with a company which offers group medical, dental and vision insurance coverage and that spouse is eligible for that plan, that spouse will not be eligible for this Plan.
2. If the spouse is employed with a company that does not offer group medical, dental and vision coverage and is eligible to be enrolled, the spouse may be enrolled in this Plan as primary at the family rate which is currently in effect. (A statement from the spouse's employer that verifies they have no coverage available with that employer will be required.)*

**Note: Medicare does not count as an employer-sponsored plan for the purposes of this rule.*

Customer Service:

SIHO has customer service representatives available to answer your questions relating to eligibility, benefits and claim status. You can also log on to their website and click on *Contact Us* to reach a customer service representative.

Phone: Local: 812.373.9703 Toll Free: 844.425.4281
Website: www.siho.org
Address: 417 Washington Street
P.O. Box 1787
Columbus, IN 47202-1787

To find out if your provider is part of the Inspire Network or to find a provider in the Inspire Network, call SIHO Customer Service or log on to the website to do a search: www.siho.org

Defining Terms

Below are terms that will appear in this benefit or on an Explanation of Benefits (EOB)

Allowed Amount: The amount allowed by the Plan after subtracting the negotiated discount.

Amount Billed: This is the amount the Provider billed for your claim before any adjustments, co-pays, deductible, or any ineligible amount.

Amount Not Covered: This amount indicates the portion of your bill that is not covered by your Plan.

Annual deductible: The amount you pay first before the plan begins paying expenses for covered services.

Out-of-pocket maximum: The maximum amount you can pay each year in deductibles and coinsurance for covered services.

Coinsurance: The percentage you pay when you receive care once you have met the annual deductible.

Co-pays: The flat fee charged by the plan for certain services such as physician office visits and prescription drugs.

Deductible: This amount reflects the deductible requirement at the time the charges were processed. You are responsible to pay this for covered health care services, before your Plan begins paying.

In-Network and Out-of-Network Providers: In-network providers are doctors, hospitals and other health care facilities that have agreed to accept a discounted payment, thereby reducing the cost of health care for you and your employer. This means you can see any provider, but the health plan pays a greater share of the costs when you use the service of an in-network provider.

Pre-certification: The process you should follow if you or a dependent is hospitalized.
Pre-certification will avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.

Network: Doctors and hospitals who've agreed to accept your insurance. Each Plan has its own network and getting care from your network is a good way to get quality care at a more reasonable cost.

Other Insurance Paid: The amount paid by another health plan or insurance company toward services you received. Examples include other health insurance, automobile insurance, homeowners' insurance, disability insurance, etc.

Out-of-Pocket Maximum: The maximum dollar amount you'll pay for covered services during your Plan year. After that, your Plan will pay for the rest of your covered care that year.

What Your Plan Paid: The amount paid by your Plan.

Your Member Discount: Your Plan negotiates discounts with health care professionals and facilities to help you save money.

SUMMARY OF HEALTH CARE BENEFITS
OPTION 1 PREFERRED PROVIDER PLAN

Your Plan Features	Option 1 - Preferred Provider Plan		
	Inspire Providers	SIHO Providers	Out-of-Network Providers
Annual Maximum	Unlimited		
Calendar Year Deductible Individual Family	$750 $1,500	$1,500 $3,000	$1,500 $3,000
* Example: The Preferred Provider Plan (Option 1) has an *embedded* deductible. This means that one member must meet the individual deductible of $750 and the remaining family member(s) can accumulate the remaining $750 to meet the $1,500 deductible. The High Deductible Health Plan (Option 2) has a *non-embedded* deductible. For family policies, *the individual deductible is non-applicable* — this means that claims of *either* one family member *or* claims accumulated by more than one member needs to meet the family deductible of $3,000 before the plan pays. However, the maximum out-of-pocket will never exceed $4,750 for one individual.			
Calendar Year Coinsurance Stop Loss Maximum Individual Family	$4,750 $9,500	$6,000 $12,000	$6,000 $12,000
Maximum Out-of-Pocket Individual Family	$4,750 $9,500	$6,000 $12,000	$6,000 $12,000
	Tier 1 and Tier 2 deductibles and coinsurance cross apply. Copays accumulate toward the maximum out-of-pocket and do not apply to Tier 3 and vice versa		
Hospital Room, Services, Supplies	80% after deductible	70% after deductible	60% after deductible
Inpatient Surgery	80% after deductible	70% after deductible	60% after deductible
Emergency Room Facility Charges ($150 copay applies if non-emergency)	80% after deductible	70% after deductible	60% after deductible
Urgent Care	80% after deductible	70% after deductible	60% after deductible
Outpatient Surgery	80% after deductible	70% after deductible	60% after deductible
Office Visits	80% after deductible	70% after deductible	60% after deductible
Preventive Health Benefit	100% covered-subject to Preventive Health Benefits Guidelines		
Diagnostic X-Ray and Lab	80% after deductible	70% after deductible	60% after deductible
Lab tests performed at Prompt Med, CRH Lab at Sandcrest or any provider sending specimens to CRH are paid at 100%. <u>This does Not apply to labs performed directly at CRH</u>	100% no deductible	100% no deductible	NA

SUMMARY OF HEALTH CARE BENEFITS
OPTION 1 PREFERRED PROVIDER PLAN

Your Plan Features	Option 1 - Preferred Provider Plan		
	Inspire Providers	SIHO Providers	Out-of-Network Providers
Ambulance	80% after deductible	70% after deductible	60% after deductible
Inpatient Mental Health and Substance Abuse	80% after deductible	70% after deductible	60% after deductible
Outpatient Mental Health and Substance Abuse	80% after deductible	70% after deductible	60% after deductible
Physical, Speech & Occupational Therapy	80% after deductible	70% after deductible	60% after deductible
Chiropractic Services	80% after deductible	70% after deductible	60% after deductible
	Annual Maximum: 30 visits		
Durable Medical Equipment	80% after deductible	70% after deductible	60% after deductible
	Precertification required for purchases over $750 and all rentals		
Hospice Care	80% after deductible	70% after deductible	60% after deductible
	Precertification required; combined Calendar year maximum: 3 months outpatient; 6 months inpatient		
Home Health Care Outpatient	100% no deductible	100% no deductible	100% no deductible
	Precertification required; Annual max 100 visits		
Other Covered Benefits	80% after deductible	70% after deductible	60% after deductible

Your Cost for Coverage

Your cost for **medical coverage** is based upon the plan you choose and your level of coverage. The following table shows your contribution for Option 1 Preferred Provider Plan.

Employee Premiums	Option 1
Individual Coverage 26 pay periods	$56.34
Employee +Spouse Coverage 26 pay periods	$112.11
Employee +Child(ren) Coverage 26 pay periods	$95.02
Family Coverage 26 pay periods	$129.23

SUMMARY OF HEALTH CARE BENEFITS
OPTION 2 HDHP

Your Plan Features	Option 2 - High Deductible Health Plan		
	Inspire Providers	SIHO Providers	Out-of-Network Providers
Annual Maximum	Unlimited		
Calendar Year Deductible Individual Family	$1,500 $3,000 Deductible is non-embedded*	$3,000 $6,000 Deductible is non-embedded*	$3,000 $6,000 Deductible is non-embedded*
* Example: The Preferred Provider Plan (Option 1) has an *embedded* deductible. This means that one member must meet the individual deductible of $750 and the remaining family member(s) can accumulate the remaining $750 to meet the $1,500 deductible. The High Deductible Health Plan (Option 2) has a *non-embedded* deductible. For family policies, *the individual deductible is non-applicable* — this means that claims of *either* one family member *or* claims accumulated by more than one member needs to meet the family deductible of $3,000 before the plan pays. However, the maximum out-of-pocket will never exceed $4,750 for one individual.			
Maximum Out-of-Pocket Individual Family	$4,750 $9,500 Copays accumulate toward the maximum out-of-pocket	$6,000 $12,000 Copays accumulate toward the maximum out-of-pocket	$6,000 $12,000 Copays accumulate toward the maximum out-of-pocket
	Tier 1 and Tier 2 deductibles and coinsurance cross apply. Copays accumulate toward the maximum out-of-pocket and do not apply to Tier 3 and vice versa		
Hospital Room, Services, Supplies	80% after deductible	70% after deductible	60% after deductible
Inpatient Surgery	80% after deductible	70% after deductible	60% after deductible
Emergency Room Facility Charges ($150 copay applies if non-emergency)	80% after deductible	70% after deductible	60% after deductible
Urgent Care	80% after deductible	70% after deductible	60% after deductible
Outpatient Surgery	80% after deductible	70% after deductible	60% after deductible
Office Visits	80% after deductible	70% after deductible	60% after deductible
Preventive Health Benefit	100% covered-subject to Preventive Health Benefits Guidelines		
Diagnostic X-Ray and Lab	80% after deductible	70% after deductible	60% after deductible

SUMMARY OF HEALTH CARE BENEFITS
OPTION 2 HDHP

Your Plan Features	Option 2 - High Deductible Health Plan		
	Inspire Providers	SIHO Providers	Out-of-Network Providers
Ambulance	80% after deductible	70% after deductible	60% after deductible
Outpatient Mental Health and Substance Abuse	80% after deductible	70% after deductible	60% after deductible
Physical, Speech & Occupational Therapy	80% after deductible	70% after deductible	60% after deductible
Chiropractic Services	80% after deductible	70% after deductible	60% after deductible
	Annual Maximum: 30 visits		
Durable Medical Equipment	80% after deductible	70% after deductible	60% after deductible
	Precertification required for purchases over $750 and all rentals		
Hospice Care	80% after deductible	70% after deductible	60% after deductible
	Precertification required; combined Calendar year maximum: 3 months outpatient; 6 months inpatient		
Home Health Care Outpatient	80% after deductible	70% after deductible	60% after deductible
	Precertification required; Annual max 100 visits		
Other Covered Benefits	80% after deductible	70% after deductible	60% after deductible

Your Cost for Coverage

Your cost for medical coverage is based upon the plan you choose and your level of coverage.
The following table shows your contribution for Option 1 Preferred Provider Plan.

Employee Premiums	Option 2
Individual Coverage 26 pay periods	$39.11
Employee +Spouse Coverage 26 pay periods	$76.15
Employee +Child(ren) Coverage 26 pay periods	$62.38
Family Coverage 26 pay periods	$89.83

Individuals signing up for the High Deductible Health Plan will receive a $500 contribution to their Health Savings account. A contribution of $250 will be made to their HSA in January and a $250 contribution in July. Employees with more than one member on the plan will receive $1000. Contributions of $500 to their HSA will be made in January and $500 will be made in July.

SIHO INSURANCE SERVICES

Preventive Health Benefits

These benefits are fully compliant with the Affordable Care Act (PPACA).

Wellness Exam:

Men - One per year

Women - One per year with family physician, one per year with OB/GYN, if needed

Childhood Immunizations

Vaccine	AGE>	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19-23 months	2-3 years	4-6 years	7-10 years	11-12 years	13-18 years	16-18 years
Diphtheria, Tetanus, Pertussis				DTap	DTap	DTap		DTap				DTap		Tdap		
Human Papillomavirus														HPV 3 Doses		
Meningococcal ACWY														1 dose		1 dose
Influenza						Influenza (yearly)										
Pneumococcal				PCV	PCV	PCV	PCV				PPSV					
Hepatitis A							Hep A 2 Doses				Hep A Series					
Hepatitis B		Hep B	Hep B			Hep B							Hep B Series			
Inactivated Poliovirus				IPV	IPV	IPV						IPV				
Measles, Mumps, Rubella							MMR					MMR				
Varicella*							Varicella					Varicella				
Rotavirus				RV	RV	RV										
Haemophilus Influenzae Type B				HIB	HIB	HIB	HIB									
Meningococcal B																MenB 2 Doses

*Varicella expanded for 2nd dose to ages 18 and over.

Services for Children and Adolescents

• Gonorrhea preventative medication for eyes • Hearing Screening • Hemoglobinopathies (sickle cell) • Congenital Hypothyroidism • Phenylketonuria (PKU)	Newborns	Developmental/ Behavioral Assessment/Autism	All Ages
Fluoride Supplement	Children without fluoride in water source	Hematocrit or Hemoglobin Screening	All Ages
Iron Screening and Supplementation	All Ages	Lead Screening	For children at risk of exposure
HIV Screening	Age 15 and above	Screening for latent tuberculosis infection	Children determined at risk
Visual Acuity Screening	Up to age 5	Dyslipidemia Screening	All Ages
Oral Dental Screening	During PHB visit	Height, Weight and Body Mass Index measurements	All Ages
Urinalysis	All Ages	Medical History	All children throughout development
Depression Screening	Ages 12 to 18 years	COVID-19 Test	Per Clinician
Education & Counseling for prevention of Tobacco Use	School-Aged Adolescents		

Services for Pregnant Women

Aspirin	For Those At Risk
HIV Screening	1 per Pregnancy
Bacteriuria	Lab test
Hepatitis B	Lab test
Iron Deficiency Anemia Screening	Lab test
Gestational Diabetes Screening (between 24 & 28 weeks)	Lab test
Rh Incompatibility	Lab test
Syphilis Screening	Lab test
Chlamydia Screening	Lab test
Gonorrhea Screening	Lab test
Breast Feeding Interventions	Counseling, Support & Supplies
Tobacco and/ or Nicotine	Screening & Counseling
Folic Acid	Women capable of becoming pregnant
Referral to Counseling Intervention	For pregnant and postpartum at risk for perinatal depression
Tdap Vaccination	1 per pregnancy
Group B Strep Screening	1 per pregnancy

Services for All Women

Domestic Violence Screening & Counseling	Annually
Contraceptive Methods	Covered unless religious exemption applies
Age 21+, HPV DNA testing and/or cervical cytology	Every 3 years
BRCA Risk Assessment and Appropriate Genetic Counseling/Testing	

Adult Immunizations	
Tetanus, Diphtheria, Pertussis	Tdap once, then Td booster every 10 years after age 18
Human Papillomavirus	Women and Men to age 45
Meningococcal	2 doses ages 19+
Influenza	Every year
Pneumococcal*	Age 19-64: 1 PPSV23 dose + 1 PCV13 dose Age 65+: 1 PPSV23 dose + 1 PCV13 dose
Hepatitis A	2 to 3 doses/lifetime
Hepatitis B	3 doses/lifetime
Shingles*	Shingrix: 2 doses after age 50 Zostavax: 1 dose after age 50
Measles, Mumps and Rubella	Once after age 19 (up to two vaccinations per lifetime)
Varicella	2 doses
Meningococcal B	2 doses, if not done between ages 16-18

*This means adult patients may get as many as 2 doses of PPSV23 and 2 doses of PCV13

Adult Procedures/Services	
Bone Mineral Density Screening	Every 2 years age 65 or older or every 2 years less than 65 with risk factors (men and women)
Mammogram - including 3D	Baseline - women, once between ages 35-39
Mammogram - including 3D	Yearly for women over 40
Sigmoidoscopy	Every 3 years after age 50
Colonoscopy	Every 10 years after age 45
Abdominal Aortic Aneurysm Screening	For men who have smoked - one time between ages 65-75
Low Dose Aspirin	At risk initiate treatment ages 50-59
Lung Cancer Screening	At risk Ages 55-80
Statin Preventative Medication	At risk Ages 40-75

Adult Labs	
Lipid Panel	Yearly
Total Serum Cholesterol	Yearly
PSA	Yearly Men over 50
Fecal Occult Testing	Yearly after age 50
Highly Sensitive Fecal Occult Blood Testing	Yearly after age 45
FBS (Fasting Blood Sugar)	Yearly
Hgb A1C	Yearly
HIV Testing	Yearly age 15 to 65 Age range may deviate based on risk.
Syphilis Screening	At risk
Chlamydia Infection Screening	Yearly - All ages
Gonorrhea Screening	Yearly - All ages
Hepatitis B & Hepatitis C Screenings	Yearly
Urinalysis	Yearly
Screening for latent tuberculosis infection	At risk
Intensive multicomponent behavioral interventions	Primary care adult patients with MBI > 30
COVID-19 Test	Per Clinician

It is recommended that a preventive health visit include screenings and counseling for:	
Healthy Diet	Intimate Partner Violence for Men and Women
Obesity	Alcohol Misuse
Tobacco Use & FDA Approved Medication	Sexually Transmitted Infections
Blood Pressure	Depression
Skin Cancer Prevention	Developmental/Behavioral Assessment/Autism
Breast Cancer Chemoprevention for Women at High Risk	Fall Risk

The **Preventive Health Benefit Guidelines** are developed and periodically reviewed by our Quality Management Committee, a group of local physicians and health care providers. The QMC reviews routine care services from the American Academy of Family Practice Standards, American College of OB/GYN Standards, Center for Disease Control Recommendations, American Cancer Society Recommendations, American Academy of Pediatric Standards and U.S. Preventive Services Task Force Recommendations.

These recommendations were combined with input from local physicians and the standard Preventive Health Benefit was developed. These standards and recommendations are reviewed every one to two years, and the benefits are updated as needed.

Please note that your physician may recommend additional tests or screenings not included in this benefit. If you receive routine screenings that are not listed in this brochure you may have financial responsibility for those charges.

A screening procedure performed when there is a family history or personal history of a condition (and which does not fall within the listed age/frequency criteria of the Preventive Health Benefit) will be covered under the major medical benefit.

*Please contact SIHO Member Services at 800.443.2980 for specific coverage information.

PHB Revised 9/2020
Effective 1/1/2021

Summary of Prescription Drug Coverage

Your Plan Features*	Option 1 - Preferred Provider Plan		Option 2 - High Deductible Health Plan*	
	Retail Service (30 day supply)	Mail Order Service (90 day supply)	Retail Service (30 day supply)	Mail Order Service (90 day supply)
Generic	$10	$25	20% after deductible	20% after deductible
Brand	$30	$60	20% after deductible	20% after deductible
Non Formulary Brand	$50	$120	20% after deductible	20% after deductible

* Prescription Drugs listed on the High Deductible Health Plan Health Savings Account Preventive Therapy Drug List will be covered at the appropriate coinsurance and not subject to the annual deductible.

An important part of any medical plan is prescription drug coverage. You receive coverage for both generic and brand name drugs, but you pay less for brand name drugs that are a part of the plan's formulary, or preferred drug list. The plan's formulary drugs are chosen by the plan based on their quality, safety, and cost-effectiveness.

You also have the option to take advantage of the Mail Order Service program. By using the mail order program you can receive 90 days of medication for less than the cost of three 30-day prescription fills at a retail pharmacy. This saves you time and money.

Effective 2/1/18, in conjunction in Indiana State Law, physicians cannot prescribe more than a 7 day supply of Opioids for patients who have not taken opioids previously and for patients under the age of 18. Future fills will require a letter of medical necessity from the physician to be submitted to SIHO Medical Management for approval.

For questions on your prescription coverage, please contact Optum at:

www.optumrx.com
Toll Free: 855-524-0381

HSA Contributions

For those employees choosing a Health Savings Account (HSA) option, the City will make payment for those employees actively employed by the City at the time of the payment and for employees who are working 30 or more hours per week. The payment will be made in two installments, the first in January and the second in July.

$1,500/$3,000 Plan:

$500 Single
$1,000 Employee + Spouse
$1,000 Employee + Child(ren)
$1,000 Family

You may contribute to your HSA the maximum amount as determined by the IRS, regardless of your plan's deductible. The maximum for 2021 is $3,600** for individuals and $7,200 for families. If you have not been working at the City of Columbus long enough to receive a paycheck, you will not be eligible for the employer HSA contribution amount indicated above.

Individuals 55 and older may contribute an additional $1,000 each year for self only or family level contributions.

The IRS only allows "embedded" deductibles for family HSA plans whose individual deductibles satisfy the minimum family deductible as determined by the IRS ($2,700). Since the $1,500 HSA plan's family deductible is $3,000, the $3,000 must be met by either an individual or family combined before benefits will start.

Early retirees are eligible to enroll in the High Deductible Health Plan but are not eligible for the employer contribution to the Health Savings Account.

The bank account connected to the City of Columbus HSA Plans is through First Financial Bank. If you are enrolling in an HSA for the first time, shortly after you submit your enrollment form, you will receive instructions on how to setup your First Financial HSA Account.

First Financial Bank offers great banking benefits to City of Columbus Employees such as Online Receipt Storing and Online Banking and Bank to Bank Transfers.

Why Choose an HSA Plan?

An HSA is a bank account where tax-free deposits are made to pay for qualified medical expenses. Withdrawals from your HSA are also tax free as long as the funds are used for qualified medical expenses. There are many advantages to enrolling in a qualified High Deductible Health Plan and opening a HSA bank account.

You are eligible to enroll in one of the City of Columbus Employee HSA Plans if you meet the following requirements:

- Have no other first-dollar medical coverage. This means you cannot be covered as secondary under a plan that is not a qualified High Deductible Plan.
- Are not enrolled in Medicare. Medicare eligible persons who do not enroll in Medicare may have an HSA if they are covered by a qualified High Deductible Health Plan.
- Cannot be claimed as a dependent on someone else's tax return

<u>What are the benefits of an HSA?</u>

- Your high deductible insurance and HSA protect you against high or unexpected medical bills
- Your health insurance premiums are lower
- SIHO pays 100% of covered preventive care services received in-network. You do not need to meet the deductible for covered preventive care services.
- You can use the funds in your account to pay for the following:
    - Medical Expenses including expenses that are not covered under the SIHO Medical Plan (See IRS Publication 502)
    - All options under IRS Publication 502
    - Long-Term Care Insurance
    - Dental and Vision expenses
    - Medical expenses after retirement (before Medicare)
    - Out-of-pocket expenses when covered by Medicare
- You can save the money in your account for future medical expenses and grow your account through investment earnings. HSA earnings grow tax-free.
- Your HSA is completely portable. Funds in your HSA belong to you and are always 100% vested. There are no "use it or lose" rules for HSAs.
- Unlike contributions into an HSA, an individual need not be covered by an HDHP to make withdrawals from the HSA. For example, an employee that is qualified to contribute to an HSA can use the funds to pay for medical expenses for a qualified dependent even if the dependent is not covered under an HDHP.

<u>Paying for medical expenses:</u>

Here are a few simple tips to keep in mind:

- When you receive services from a physician or hospital, present your SIHO Identification Card just as you would with a traditional plan. Use of the ID Card ensured that the claims will be submitted to SIHO and that a provider network discount will be taken. This saves money for you! Most providers will not require payment from you at the time of service; they will bill SIHO and wait for payment determination from SIHO before billing you.
- Qualified healthcare expenses may be paid with your HSA money, or you may pay out-of-pocket and continue to save in your HSA.
- Your HSA works like a checking account with withdrawals limited only by the account balance.
- After you open your HSA, you have the option to receive a First Financial Debit Card. This card can be used to pay for qualified expenses anywhere it is accepted. You may also setup bill-payer and pay your medical bills online with First Financial.
- Receipts of where you spend your HSA funds are required by the IRS. You do not need to submit a receipt to the bank to receive reimbursement.
- However, you need to keep the receipt for 7 years with your other tax reporting paperwork.

Health Savings Account Example

	PPO Plan ($1,500 Family Deductible)	HSA ($3,000 Family Deductible)
Annual Premium	$3,163.16	$2,198.82
Employee HSA Deposit	$0	$750
City of Columbus HSA Match	$0	$1,000
*Assumed Annual Medical –750 expenses not covered by insurance	$750 (paid out of pocket)	$750 (paid from HSA Account)
Total Employee Cost	$3,913.16	$2,948.82
HSA Account Balance at end of year	$0	$1,000 ($750 EE & $1,000 City of Columbus Deposit minus $750 Expenses = $1,000)

Taking Advantage of Your FSA

A great way to save on your health care and dependent care expenses is by taking advantage of the Flexible Spending Accounts (FSAs), including the:

- Health Care FSA and
- Dependent Care FSA

Health Care FSA*

The Health Care FSA gives you a smart way to save on eligible expenses not covered by the new program by allowing you to set aside money on a pre-tax basis to pay for these expenses. Some examples of eligible expenses include:

- Deductibles for medical and dental plans
- Physician's fees
- Laboratory fees
- Prescription glasses or contacts
- Prescription drug co-pays
- Some types of medical equipment or supplies
- Surgical or diagnostic services

An FSA allows you to set aside up to $2,750** on a pre-tax basis that can be used for non-reimbursed health care expenses for you and your qualified dependents throughout the year. Here's how it works:

First, decide how much you want to contribute. A regular amount will be automatically deducted from each paycheck for the entire year. Your elected funds will be available at the beginning of the plan year and funds are reimbursed to you as expenses are submitted up to the amount elected for the year.

Then, when you or a qualified dependent have eligible expenses not covered by the benefits program OR any or all health benefits are exhausted, your FSA administrator reimburses you from your flexible spending account. Your expenses are reimbursed from your account and you avoid the taxes you would otherwise pay on that money.

* If you are participating in the HSA Qualified Plan, you are only eligible to participate in a *limited purpose* Health Care FSA. This means that you will only be able to submit Dental and Vision expenses.

Dependent Care FSA

The Dependent Care FSA works similar to the Health Care FSA. It allows you to set aside up to $5,000 each year on a pre-tax basis for reimbursable day care expenses, such as fees for a licensed day care center or adult day care, for eligible dependents ($5,000 maximum for the head of household or a joint tax return and $2,500 maximum for married, separately filed tax returns). For this account, funds must be contributed first in order to be eligible to be claimed.

**The FSA Amount is subject to change per Federal Guidelines. Please refer to the IRS website for further information.

Important FSA Facts:

There are restrictions imposed by the federal government that you need to keep in mind before participating in an FSA:

- You cannot stop, start, or change the amount of money you contribute during the year unless you experience a Qualified Life Event change. If this occurs, then your change must be consistent with your qualified life event change. Under the Dependent Care FSA, a Cost of Coverage change is eligible for contribution adjustments.
- You may use the money in your account to pay for expenses you or your dependents incur only during the same calendar year. Any money remaining in your account, after you have applied for reimbursement for the year, is forfeited and cannot be returned for any reason. For FSA, the Internal Revenue Service will allow participants to roll over a maximum of $550 from your healthcare or limited FSA to the next plan year.
- Your Health Care and Dependent Care FSAs are separate. You cannot transfer money between the two accounts.
- When submitting claims, you must attach an itemized receipt (cancelled checks do not qualify as a valid receipt). An EOB, or Explanation of Benefits, can be submitted for reimbursement.
- You must re-enroll in the FSA each year.

FSA – Continued

Premium and Flexible Spending Accounts Illustration:	
Pre-Tax With FSA	**After Tax Without FSA**
$1,000 Your pay check - 150 Dependent Care FSA - 20 Medical FSA $ 830 Taxable Amount - 207 Amount taxed on your income **$ 623 Spendable Income**	$1,000 Your pay check (taxable amount) - 250 amount taxed on your income* $ 750 - 150 Dependent Care** * 20 Medical Expenses (if eligible)** **$ 580 Spendable Income**
Per Payroll Savings $43.00	**Annual Savings $1,118.00**
*Based on a 25% tax bracket. Your actual tax savings could vary. ** If you would incur these expenses.	

FSA Debit Card

The FSA debit card allows a participant to use the card at the point of purchase to pay for qualified expenses instead of using their personal funds and waiting for reimbursement.

Advantages:

- Significant reduction in number of claims to submit for reimbursement
- Convenient access to your plan dollars at the point of purchase

The Pre-Tax Advantage

Don't forget that the money you contribute toward your medical and dental coverage is paid on a pre-tax basis (except for non-qualified domestic partners). This means that:

- The costs for your benefits are deducted from your paycheck before you pay any federal income or Social Security taxes (except for non-qualified domestic partners).
- This deduction reduces your taxable income – the amount on which you pay taxes.
- Reduced income tax means you have more take-home pay.

Member Portal

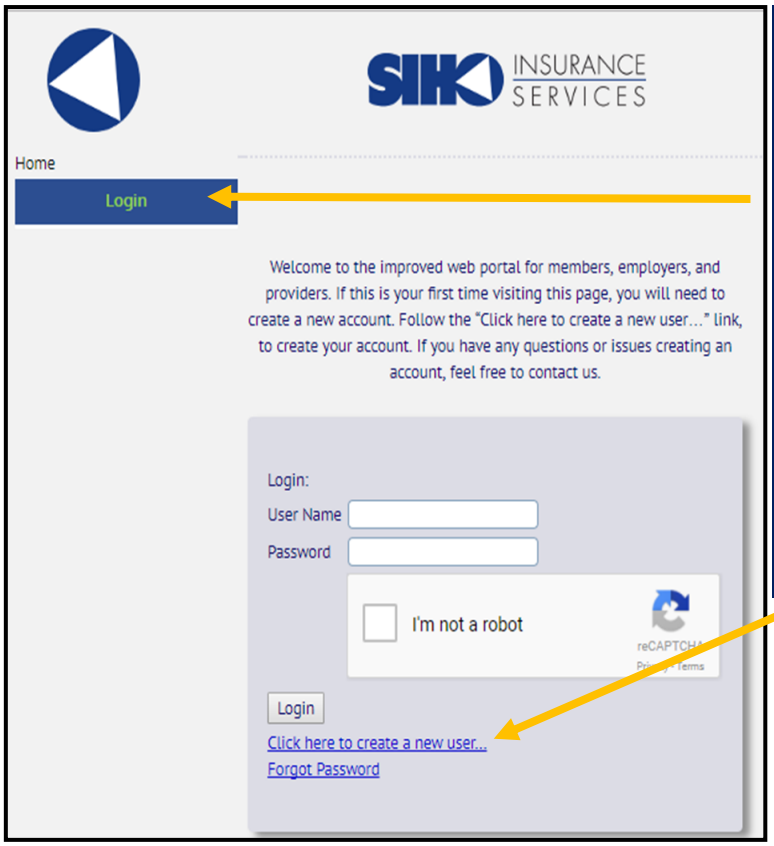
As a feature of your health care benefits, SIHO provides **secure** internet access to give you information you need anytime you need it. Some of these features include:

Claims
SIHO provides quick access to your claims status and eligibility information. You can track your medical claims as they move through the SIHO claims processing system.

Utilization
View up-to-date information on Deductibles, Out-of-Pocket Limits & Preventive Health Benefits usage.

Provider Lookup
Search for healthcare providers in your network by Specialty, Name or Location.

Plan Documents
Verify benefits related to your current plan.

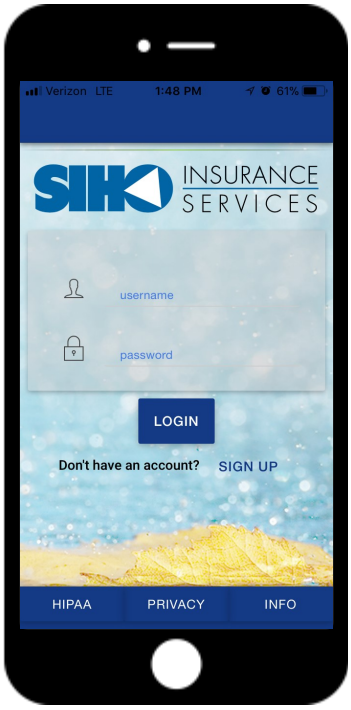


Visit https://my.siho.org/
to access the Member Access Portal.

Select Login. If you are a new user, select "Click here to create a new user id" and follow the on-screen instructions.

You may be directed to select a specific health plan when creating your account. If you are unsure which plan you should select, please contact
SIHO Member Services:
812.378.7070

SIHO Mobile App



Want to look up the status of a medical claim? Or email your health insurance ID Card? How about checking your eligibility information or sending a question to your health insurance provider? SIHO Mobile puts the most popular online features of our member web portal at your fingertips. Check a claim, view your virtual member ID card, access your eligibility information, or just ask a question. The SIHO mobile app is now available for iPhone, iPad, iPod Touch and Android devices.

FEATURES

My Summary (Benefits and Coverage Information),
ID Card (ID Card Information), Claims (Medical, Dental, Lab, Pharmacy),
About Us, AND MORE.

VIEW YOUR BENEFITS AND COVERAGE INFORMATION

Until you experience it, you may never have realized how helpful it is to have your benefits and coverage information right at your fingertips.

VIEW YOUR MEMBER ID CARD

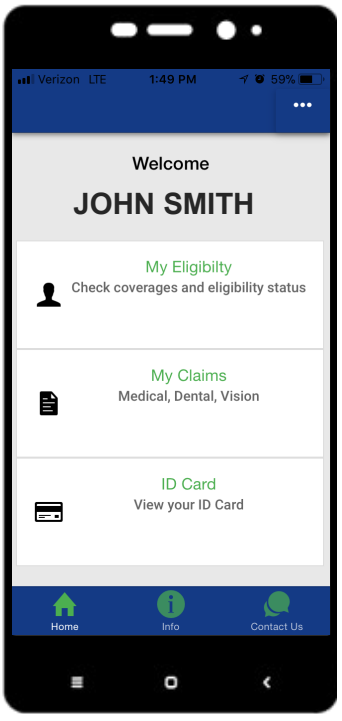
You can view the information on the front and back of your ID Card. You can also email the card information to your provider or whomever requires it at any time.

LOOK UP CLAIMS

See your recent claims—up to ten per screen. Get a detailed view of each one, or look up specific medical, dental and pharmacy claims by member name.

SECURITY

You must always sign in with your **User Name** and **Password** to access the features in this app. Without that information, no one can reach your personal data. It is safe.



For Apple devices, visit the **Apple App Store**.
For Androids, visit the **Google Play Store**.
Search under SIHO.

Important Information

Newborns' & Mothers' Health Protection Act

Under the Newborns' Act, the plan may not restrict benefits for a hospital stay in connection with childbirth to less than 48 hours (96 hours in the case of a cesarean section), unless the attending provider (in consultation with the mother) decides to discharge earlier.

Plans may not require providers to obtain authorization from the plan for prescribing the stay. In addition, plans may not deny a stay within the 48-hour (or 96-hour) period because the plan's utilization reviewer does not think such a stay is medically necessary.

The plan must eliminate this preauthorization requirement with respect to hospital stays in connection with childbirth for the first 48 hours (or 96 hours in the case of a cesarean section). The plan may impose such an authorization requirement for hospital stays beyond this period. In addition, the plan may impose a requirement on the mother to give notice of a pregnancy in order to obtain a certain level of cost-sharing or to use certain medical facilities. However, the type of preauthorization required by this plan (within the 48/96 hour period and based on medical necessity) must be eliminated.

Women's Health & Cancer Rights Act of 1998

In accordance with the Women's Health and Cancer Rights Act of 1998, SIHO Insurance Services' covered members who undergo a mastectomy, and who elect breast reconstruction in connection with the mastectomy, are entitled to coverage for:

- Reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetric appearance.
- Prosthesis and treatment of physical complications at all stages of the mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

The coverage may be subject to coinsurance and deductibles consistent with those established for other benefits.

Premium Assistance Under Medicaid & the Children's Health Insurance Program

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of August 10, 2017. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid: Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to- z/hipp Phone: 1-888-346-9562
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website:http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website:http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website:https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100

MASSACHUSETTS – Medicaid and CHIP	NORTH DAKOTA – Medicaid
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	OREGON – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	PENNSYLVANIA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	RHODE ISLAND – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	SOUTH CAROLINA – Medicaid
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	WEST VIRGINIA – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	WYOMING – Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

CLICK
www.siho.org

CALL
812.378.7000

CONNECT
facebook.com/SIHOInsuranceServices

SIHO INSURANCE SERVICES

The plans illustrated in this brochure are representative examples. Because plan details change from time to time, your plan may have different benefits. Refer to your Certificate of Coverage for the specific benefits available to you. For more information on these plans, contact your authorized SIHO agent/broker or SIHO account coordinator.